BELOW ARE THE STEPS FOR OBTAINING APMA AND COMPONENT MEMBERSHIP FOR DPMS WITHIN THE UNITED STATES (NOT CURRENTLY IN A POSTGRADUATE PROGRAM).

1. LOCATE THE APPROPRIATE COMPONENT CONTACT INFORMATION BY GOING TO www.apma.org/statecomponents. CONTACT THE COMPONENT SOCIETY WHERE YOUR PRIMARY PRACTICE IS LOCATED. THEY WILL PROVIDE YOU WITH DETAILS REGARDING ANY ADDITIONAL DOCUMENTATION TO SUBMIT AS WELL AS REQUIRED DUES PAYMENT.

2. PRINT THE BELOW MEMBERSHIP APPLICATION.

3. COMPLETE THE APPLICATION AND MAIL DIRECTLY TO THE APPROPRIATE COMPONENT ALONG WITH ANY ADDITIONAL DOCUMENTATION REQUIRED. EXAMPLES OF ADDITIONAL DOCUMENTATION MAY INCLUDE A COPIES OF YOUR STATE LICENSES, STATIONERY, BUSINESS CARD, ETC. REMEMBER TO INCLUDE YOUR COMPONENT AND NATIONAL DUES.

4. UPON RECEIPT YOUR COMPONENT WILL COMPLETE PROCESSING TO ACTIVATE YOUR MEMBERSHIP. YOUR COMPONENT WILL FORWARD APPROPRIATE DOCUMENTATION AND DUES PAYMENT TO APMA AND YOU WILL BEGIN TO RECEIVE APMA MEMBER BENEFITS.

5. IF YOU HAVE ANY QUESTIONS, CALL THE APMA MEMBERSHIP SERVICES DEPARTMENT AT 1-800-ASK-APMA.
Application for Membership

I hereby apply for membership in the component association of the state in which I have my principal practice and to the American Podiatric Medical Association (APMA). If elected, I agree to uphold and abide by the purposes, bylaws, code of ethics, and all rules and regulations of my component association and the APMA. I understand that no one has an automatic right to be elected to membership in this voluntary organization.

Last Name _________________________________ First ________________________ Middle _________

Previous Last Name (changed due to marriage, divorce, etc.) ______________________________________

Birth Date _____ / _____ / ________ Nickname _____________________________________________

Social Security No. (optional): ___________________________ Gender: ☐ M ☐ F

Ethnic Group (for demographic use only): ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian/Pacific
     ☐ American Indian ☐ Other _____________________________________________

Spouse’s Name___________________________________________ US Citizen (optional): ☐ Yes ☐ No

☐ Home Address*: __________________________________________
                   County _______________________________

Telephone (       ) ________________________ Fax (       ) ________________________

Home e-mail**: __________________________________________
                   Cell (       ) ________________________
                   Pager (       ) ________________________

☐ Principal Office/Residency Address:
                               County _______________________________

Telephone (       ) ________________________ Fax (       ) ________________________

Office e-mail**: ________________________ Office Web Site: _______________________

☐ Second Office Address:
                               County _______________________________

Telephone (       ) ________________________ Fax (       ) ________________________

Office e-mail**: ________________________ Office Web Site: _______________________

☐ Third Office Address:
                               County _______________________________

Telephone (       ) ________________________ Fax (       ) ________________________

Office e-mail**: ________________________ Office Web Site: _______________________

If you have more than three office addresses, please list on a separate sheet.
**Education**

**Undergraduate Degree**

Year ______  State ______  Institution ____________________________________  Degree ______

**Graduate Degree**

Year ______  State ______  Institution ____________________________________  Degree ______

**Podiatric Medical Degree**

(See back panel for listings)

Check College Below  Year of Graduation ____________  □ Arizona  □ Barry  □ California
□ Des Moines  □ New York  □ Ohio  □ Temple  □ Scholl  □ Western  □ Other

**Postgraduate Education**

☐ Yes (If yes, complete)  ☐ No

☐ Preceptorship
☐ Fellowship

☐ Residency (check one only):
  □ Rotating Podiatric Residency (RPR)  □ Podiatric Orthopedic Residency (POR)
  □ Primary Podiatric Medical Residency (PPMR)  □ Primary Surgical Residency (PSR)
  □ Podiatric Medicine and Surgery Residency (PM+S)

Begin Date________  State______  Institution__________________________  Completion Date________
                                                                            m o / yr                       m o / yr

☐ Preceptorship
☐ Fellowship

☐ Residency (check one only):
  □ Rotating Podiatric Residency (RPR)  □ Podiatric Orthopedic Residency (POR)
  □ Primary Podiatric Medical Residency (PPMR)  □ Primary Surgical Residency (PSR)
  □ Podiatric Medicine and Surgery Residency (PM+S)

Begin Date________  State______  Institution__________________________  Completion Date________
                                                                            m o / yr                       m o / yr

**Military**

**Military Service**

☐ USA  ☐ USAF  ☐ USN  ☐ USMC  ☐ USCG  Other ______________________________

Date Entered_______________  Date Separated__________________  Current Rank___________________

☐ Reserves  If yes, branch of service ___________________________________________________________________

**Professional Licensure**

**Podiatric Medical Licenses**

Year____  State____  Number____________  Year____  State____  Number____________
Year____  State____  Number____________  Year____  State____  Number____________
Year____  State____  Number____________  Year____  State____  Number____________

Have you ever had a license to practice podiatric medicine suspended, denied, or revoked by any licensure authority?
☐ Yes  (If yes, please explain on a separate sheet.)  ☐ No

Are you currently, or have you ever been, on probation, suspension, or investigation by any licensure authority, state, or federal agency?
☐ Yes  (If yes, please explain on a separate sheet.)  ☐ No

**Podiatric Medical Practice**

**Original Practice Start Date**

Month______  Day______  Year______
APMA-Recognized Organizations
(check only those in which you have certification/membership)

Board Certification (See back panel for listings)
☐ ABPS  ☐ ABOPOP

Affiliated Membership (See back panel for listings)
☐ AAHHP  ☐ AAPP  ☐ AAPSM  ☐ AAWP  ☐ ACFAOM
☐ ACFAP  ☐ APMWA  ☐ ASPD  ☐ ASP  ☐ ASPS

Previous Member of APMA
☐ Yes (If yes, complete)  ☐ No
Dates _______________ Component Association ______________________________________________

Signature/Instructions
Please be aware that you may be required to provide additional documentation (copy of all state licenses, business card, sample of stationery, etc.) to your component society.

I understand that dual membership (state component and national association) is required to be a member in good standing. I agree not to represent myself as a member of APMA or my component, if for any reason, I cease to be a member in good standing. I also understand that a portion of my annual dues is in payment for a one year subscription for the APMA NEWS and for the Journal of the American Podiatric Medical Association. I agree that incomplete or false information may be grounds for denial or termination of membership.

APMA dues are not deductable as a charitable contribution for federal tax purposes but may be deductable as a business expense.

*If you are a practicing DPM, it is important to contact the state component in which your primary practice is located.* Contact information can be found on-line at www.apma.org/StateComponents. Your component will inform you of the amount of dues to remit as well as any other required documentation. An overview of membership processing procedures of each component can be viewed at www.apma.org/MembershipProcess. Your completed application and dues payment must be sent directly to your component, not the APMA.

*If you are a DPM in post-graduate training, send your completed application and dues payment directly to APMA.* A current dues chart for DPMs in post-graduate training can be viewed at www.apma.org/PostGraduateDuesSchedule.

If you have any questions, please contact the APMA Membership Services department at 1-800-ASK-APMA.

Applicant Signature: __________________________________________, DPM  Date: _______________

I was recruited for APMA membership by the following APMA member:
**Listing of Podiatric Medical Colleges**

Arizona: Arizona Podiatric Medicine Program at Midwestern University—Glendale
Barry: Barry University School of Podiatric Medicine
California: California School of Podiatric Medicine at Samuel Merritt University
Des Moines: Des Moines University College of Podiatric Medicine & Surgery
New York: New York College of Podiatric Medicine
Ohio: Ohio College of Podiatric Medicine
Temple: Temple University School of Podiatric Medicine
Scholl: Dr. William M. Scholl College of Podiatric Medicine at Rosalind Franklin University of Medicine & Science
Western: Western University of Health Sciences College of Podiatric Medicine

**Listing of Boards**

ABPOPMM American Board of Podiatric Orthopedics and Primary Podiatric Medicine
ABPS American Board of Podiatric Surgery

**Listing of Affiliated Organizations**

AAHHP American Association of Hospital and Healthcare Podiatrists
AAPPM American Academy of Podiatric Practice Management
AAPSM American Academy of Podiatric Sports Medicine
AWP American Association for Women Podiatrists
ACFAOM American College of Foot and Ankle Orthopedics and Medicine
ACFAP American College of Foot and Ankle Pediatrics
APMWA American Podiatric Medical Writers’ Association
ASPD American Society of Podiatric Dermatology
ASPM American Society of Podiatric Medicine
ASPS American Society of Podiatric Surgeons

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**For Component Society Use**

Component name:

Division (If applicable):

Date application was received:

Date sent to APMA:

Join date:

Member category:

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**For APMA Use Only**

Dues Amount

Member No.

Member Type

Date Received

Elect Date

02/10